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ABSTRACT

Feminist therapy, born of activism and opposition to the bias within conventional psychotherapy, is most often defined by its emancipatory goals for women and its approach to treatment which examines the link between the patient's problem and systemic discrimination. In this study, 20 feminist therapists were interviewed in order to explore the way in which feminism is manifested in their psychotherapy practice. Respondents described the defining characteristic of their feminist practice as the nurturing, compassionate, and respectful nature of the therapist-client interaction. Feminist therapy, having developed outside academia, has resulted in intellectual isolation of the practitioners from the ongoing debates among scholars. Among issues discussed are gender essentialism, relational theory, and moral relativism versus absolute feminist values. Rather than a vision of feminist therapy that joins feminist ideology with psychotherapy, the respondents graft elements of feminism onto the process of their practice. This acts to guide the patient to the goal of personal fulfillment from within the existing power structure, rather than challenge it. (LSR)

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A Room of One's Own: Power and Agency in Feminist Therapy

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Psychotherapy has been a target of feminist activism since the Women's Liberation Movement of the 60s and 70s. Feminists have charged that traditional clinical theories about women were little more than ideologically-driven pseudo-science, and that the practices of therapists often privileged interests of men and demeaned women. Feminists also have argued that psychotherapy and other mental health treatments aimed to adjust women to oppressive conditions instead of challenging those conditions.

Feminist therapy was born in this oppositional spirit. Practitioners in various schools of psychoanalysis, humanistic therapy, family therapies, cognitive behavior therapy worked to re-invent therapy in accord with feminist principles. These efforts to devise feminist forms of therapy have not been unitary, nor has the course of development been linear. Instead, what has resulted is a variegated tapestry of feminist therapies, one that weaves together differing modes of therapy and differing philosophies, politics, and principles associated with feminism.

Practitioners of feminist therapies operate within a complicated and contradictory arena. As therapists, they are part of an elaborate professional culture that constrains what can be seen and said. This culture, as many have suggested, is closely allied with modern liberal individualism, and shares many of its assumptions and values (Cushman, 1996; Espin & Gawalek, 1992; Hare-Mustin & Marecek, 1990; and Richardson, Fowers, & associates, forthcoming). These include the notion

of a private self that stands outside history and culture, the importance of individual self-realization, and the possibility and desirability of free choice uninfluenced by the culture and society surround. Many feminist thinkers, along with other social critics, have been critical of modern individualism, and problematized its notions of self, choice, and freedom. In academic psychology too, critics have disputed the modernist conceptions of self on which much clinical theory was built: its interiority, its unity and consistency, its separateness from social relations, and its autonomous, pre-existent quality. How do feminist therapists -- with one foot in the culture of psychotherapy and the other in feminism -- negotiate these points of view?

The cultural and material conditions of the 1990s pose additional challenges for feminist therapists. As psychotherapists, they are subjected to the sweeping re-medicalization of the mental health field, and by the demands for efficiency and cost-cutting associated with corporatization. As feminists, they are part of a movement that has grown to have many diverse political and intellectual strands. Even more difficult, feminists must contend with a severe media backlash and (at least in the US) an overall cultural swing toward social conservatism. Feminists who do therapy, we conjecture, confront such social trends more directly than academic feminists, who are shielded by the relative liberalism of college campuses.

This paper concerns therapists who identify themselves as feminists and say they bring a feminist perspective to their work. We study their accounts of themselves, their feminism, and its influence on their work as therapists. What are the terms of their engagement with feminism? How do their accounts manage contradictions between their

feminist commitments and their psychotherapeutic commitments? How does psychotherapy culture (and its characteristic discourse) "constrain what can be seen and said" for these therapists?

Therapists were recruited from a variety of work sites, including state and private agencies, college counseling centers, and private practices. All were from the state of Wisconsin; most were located near the university town of Madison. Screening interviews conducted by telephone to verify that the therapists considered themselves feminist therapists. In accord with the long-standing custom in the field, we took self-identification as a feminist therapist as a sufficient (and necessary) condition for inclusion in the sample. This analysis focuses on 20 therapists: 13 psychologists (8 with doctorates), 2 psychiatrists, and 5 social workers. All were women and all had considerable experience as therapists (Median = 14 years; range, 5 -- 28 years).

The interviews were conducted in private by advanced social work students. The interview guide contained open-ended 19 questions, and the respondents were encouraged with prompts and probes to express their ideas fully. Most interviews lasted between one and a half and two hours.

The therapists in this study spoke confidently about their abilities and success as therapists. They were committed to working as therapists and they derived considerable satisfaction from their work. Moreover, they spoke with conviction and certainty about their feminist beliefs. Yet, from our vantage point as feminist academics, the terrain of psychotherapy looks as perilous for feminists today as at any time in the 25-year history of feminist therapy. We focus attention on moments of

accommodation, resistance, and contradiction in therapists' accounts of themselves and their work. In what follows, we take up five such areas.

1. Where is the feminism in feminist therapy?

Writings about feminist therapy have often identified its distinctive feature as its emancipatory goals for women. Some writers (such as Alexandra Kaplan, 1976; and Sandra Bem, 1976) used "re-socialization" as a metaphor for therapy; for others (such as Annette Brodsky, 1973; Maria Coleman, 1996; Lucia Gilbert, 1980; and Toni Laidlaw & Cheryl Malmo, 1990), it was a raised consciousness, that is, an understanding of how a woman's personal problems are linked to larger systems of discrimination and hierarchy. Yet others (for example, Miriam Greenspan, 1983) included female solidarity and political participation among their goals.

Against this backdrop, our respondents' views surprised us. We asked the question, "What does it mean to you to say that your therapy is feminist?" Most framed their answers primarily in terms of process, not goals. They did not speak about re-socialization, anger, raised consciousness, or political change. Instead, what they regarded as distinctive about feminist therapy was how a therapist "does" the therapeutic relationship. For example:

"[I]t's softer...less critical,...less dualistic...less judgmental. It's a more open way of looking at an individual.

"That all people who come through the door would be treated with dignity and respect, and compassion and equality. That's the essence of it. Safety. I would add safety to that.

So it's a kind of respectful approach to, a respectful manner toward both the concerns and the women's ways of doing things that feels different and characteristic of women"

"Humanness, nurturing, and support go to the very essence of feminist therapy."

"One of the big factors...would be that you be aware of power differentials between you and your clients and trying to minimize those."

"...a style of interacting with people....Probably a sort of basic respect for humanity."

The emphasis on process in feminist therapy was so strong that when respondents were asked to describe "a model of mental health" that accorded with their feminist principles, nearly all the respondents interpreted the question to be about how mental health services should be conducted, not about how mental health or normality should be defined.

Asked to recount incidents when their feminism and their professional training were in conflict, our respondents' answers again centered on process and the therapy relationship. For them, the feminist feature of their work was their willingness to relax client-therapist boundaries. A variety of examples were recounted -- hugging or touching a client; lending a client a piece of costume jewelry; permitting oneself to "tear up" openly when a client cried; self-disclosures (such as revealing that the therapist was a survivor of childhood abuse or a lesbian); and letting clients read the DSM and take part in selecting their diagnoses.

Respondents framed these practices in terms of boundary issues, and they expressed uneasiness about them. They were careful to insist to the interviewers that such incidents were infrequent and that, in most respects, they were vigilant in maintaining boundaries (e.g., "But I don't

let clients call me at home.") Many reported that they took pains to conceal such incidents from other therapists, who, they felt, would disapprove. Despite their ambivalence, they described these boundary "violations" as actions deliberately undertaken to accomplish therapeutic ends that were important in a feminist model: support, empowerment, and equalizing the client/therapist relationship.

In sum, our respondents indicated that it is the style of interaction -- respectful, kind, and nurturing -- that sets off feminist therapy from other approaches. Style of interaction, however, is relatively intangible. In characterizing their style, some respondents drew on contrasts and opposites to set themselves apart from conventional therapists. Whether inadvertently or not, they projected a view of conventional therapy as a single monolithic practice that is negative and harmful -- judgmental, critical, disrespectful, inhumane, "stone-cold" and distanced. We do not take a position on the accuracy of such characterizations, but we note that respect, humanness, and warmth hardly constitute radical departures from contemporary professional norms. Furthermore, many respondents described feminist therapy in terms that closely mirrored stereotypic feminine traits. Indeed, in their accounts, it was sometimes hard to disentangle whether feminist therapy proceeds as it does because therapist is a woman or because she has self-consciously adopted a feminist model. As we shall see, the conflation of woman and feminist is a recurrent theme in the accounts.

2. Essentialism in Feminist Therapy

"and the picture that came out of this, which was completely unconscious, looked almost identical to a woman's reproductive system. It is *so* amazing!" (a therapist describing a diagram she had drawn of feminist clinical supervision)

Many respondents drew upon constructs of femininity and womanliness to formulate descriptions of their therapy practices, often in language that posited an essential female nature:

"[I]t's to understand in a theoretical way the essence of being a woman, and to understand in a very individual way how the person across from me...how that is manifest in the woman."

"[I]t's an example of deep therapy because it means trying to unearth the feminine character."

"We talk through everything. That's part of the beauty of being a woman."

Many respondents framed their thoughts in terms borrowed from the writings of the Stone Center ¹, whose theories invoke an inevitable and universal female nature, set in place in the mother-infant relationship. These writings celebrate the "connectedness" and "relationality" said to be inherent in all women. Whereas other strains of feminist psychology have critiqued the sex-based division of labor and sex-based prescriptions regarding psychological traits and qualities, "relational" theory reinstates gender dichotomies and encourages women to seek fulfillment in womanly roles and femininity.

This kind of dichotomous thinking and gender essentialism is a powerful rhetorical device, one that is pervasive in popular media and in self help culture. No doubt it is familiar to therapy clients, and thus affords easy communication and rapport. But it also leads into interpretive and political quagmires, as many theorists have pointed out (Bohan, 1994; Brown, 1994; Hare-Mustin & Marecek, 1990). It mistakenly assumes that the child rearing arrangements of middle class, white, heterosexual, American families are the norm. Moreover, by

focusing on the ways in which all women are supposedly the same, it ignores cultural, class, and historical differences among women, as well as questions of power. Were differences in social location and material resources figured into the theory, power differences among women could not be so easily evaded.

Relational theory leaves the "Other" side of the gender dichotomy undescribed. The categories of men and so-called male behavior serve merely as receptacles for whatever is unwomanly or bad (Hare-Mustin & Marecek, 1994). Although most respondents drew upon this totalizing rhetoric of gender universals and gender dichotomies at some point in their accounts, it was not their only discursive mode. Their descriptions of specific experiences and individuals contradicted (albeit unselfconsciously) the rhetoric. For instance, nearly all acknowledged that some men embodied womanliness, and were "caring" and "nurturing." Moreover, all but one respondent held the view that men could practice feminist therapy. Also, some disparaged women they had encountered who were not womanly, and thus not feminist.

3. Self and Choice in Feminist Therapy

Therapeutic culture presupposes a unitary, inner, pre-existent self that resides out of reach of the influence of society and culture. This construct figured prominently in practitioners' conversation and some added the further twist that this interior, true self was gendered. Their metaphors of "going back" to the true self, "unearthing" it or "finding" it in some "inner" location implied that this true self can be retrieved by peeling away the accretions of falsity acquired through personal relationships, cultural norms, and social dictates. Furthermore, they

figured therapy as a journey of discovery and acceptance of an intrinsic woman-self that stands apart from cultural dictates and social relations:

"You have to work that through and confront that so that they can get to being able to find their real self....It's easier working with women, talking woman to woman about finding your true self."

"...that trajectory of learning about myself as a woman, that for me is the edge right now, is going back to my true selfhood: Who am I as a woman?"

"I think that there is sometimes a denial of one's feminine self because it's devalued sociologically, so in therapy we re-value the feminine self."

"...self-journeying around to explore my womanhood."

Within a discursive framework that posits an inner self, therapy becomes a matter of helping clients to make choices based on the wants and needs of the inner self set free from external influences.

"I think I give them choices. It's all about really allowing them to be who they need to be -- and I think that's the beauty of feminism. It's not confining; again, it goes back to being kind."

"The political aspect [of feminist therapy] [is] the radical nature of helping people become themselves."

"What I try to do is I...get them to move towards being the best they can be, in terms of their own definition of that."

"I let women choose, my job is not to tell people what is best for them. I just expand the range of options."

The notion that it is possible to adopt a position outside society, and thus to "act as the author of one's own subject" has been under critical scrutiny in academic circles; the scholarly action now focuses on devising alternative constructions of the self. But our respondents did not move in scholarly circles; they accepted this notion uncritically.

What possibilities for therapy are constrained and enabled by this presupposition?

As therapists shared some of their ideas about therapeutic change, some contradictory themes emerged. Although the construct of a "relational self" may seem akin to postmodern ideas of a self constituted through social relations, it is not. By staying with the idea of a private and separate self, respondents ended up posing the paradox that in order for a woman to recover her "relationality," she had to detach herself from social relations and cultural connections.

Another paradox threaded through the interviews. In keeping with a strong tradition of feminist politics, our respondents valued free choice and self-determination for women. As therapists, they viewed much of their work as fostering women's ability to choose for herself. Yet, at the same time, they posited a pre-determined feminine self -- a universal, ahistorical template of female psychology. Ultimately then, a therapist could do no more than help a woman choose to become who or what she was already destined to be. (To echo an oft-repeated phrase: "To become herself.")

The idea that a self can stand outside its engagement with history and culture and define its own subjectivity led respondents into another paradox, this one regarding their position as therapists. Many of our respondents identified value-neutrality as a principle of feminist therapy, holding that a therapist's role is to "validate clients' experience," to "honor" their values, characteristics, and life style choices. As one respondent put it, "where a client is at is where she needs to be." But this principle of unconditional acceptance had clear limits in practice. Nearly all the respondents refused to work with men

who were sex offenders, incest perpetrators, or who engaged in violence against women. Moreover, in keeping with relational theory, some respondents had definite ideas regarding the proper ways of being a woman:

"...in therapy we re-value the feminine self.

"[Feminist therapy] conveys a kind of honoring of the characteristics that women ...bring into the office"

Thus, respondents simultaneously invoked an extreme moral relativism and feminist values that they did not regard as relative. On the one hand, they upheld the principle of untrammelled free choice. But on the other, they subscribed to a set of ethical commitments grounded in a feminist vision. Feminist critics of psychotherapy (for example, Rachel Hare-Mustin 1983; Kerri James & Laurie MacKinnon, 1990; Celia Kitzinger & Rachel Perkins, 1993; and Sharon Lamb, 1996) have always begun from explicit value positions and demanded moral accountability. It is ironic that feminist practitioners should feel compelled to disavow in principle the moral/ethical dimension of feminism.

Finally, in terms of a feminist politics, the emphasis on self-transformation and self-fulfillment has added drawbacks. It defines the emancipatory project of feminism as personal fulfillment through a process of private discovery, absent social or political change.

4. The Trouble with Power

Power has never been easy for feminists to talk about. Our respondents too had trouble talking about power. They chose language that seemed to soften what they had to say, speaking of "feelings of empowerment," "moving the client into a state of empowerment," and

"empowering the 'woman's voice.'" The following interchange exemplifies the hesitancy that threaded through the interviews:

[I: How do you define power for yourself?] Well, I guess empower. I guess that's what I'd say. It enhances. Well, I guess it can be positive or negative. To me a positive way of experiencing power, viewing power, is one of empowering. It's viewing someone's strengths, sort of looking at their resources, what they have inside, their own expertise.

Others too grappled with differentiating good and bad kinds of power. For one respondent, the good kind of power was "power-to"; the bad kind, "power-over." For another, good power was "power-with," that is, "balancing the dimensions of power with involvement." Yet another articulated good and bad in terms of an explicit gender dichotomy:

"...a woman wielding masculine power can be as screwed up as a man would [be]....The difference is in the connectedness and depth. The next step...is women's reaching for a deepening, a kind of spirituality and a wisdom."

Substituting the term empowerment transforms power into something private and static instead of something fluid and constantly negotiated. The phrases like "feelings of empowerment" and "becoming empowered" bespeak a mental state more or less equivalent to self-confidence or improved self-esteem. Once power is located within a woman's psyche, empowerment can be accomplished in the confines of the psychotherapy relationship, in isolation from ongoing personal relationships or social systems. Indeed, in our respondents' accounts, empowerment seems to be a matter of finding the power a woman already has:

"My work is a lot about trying ...to facilitate women having as much of their power and range and their self as they can."

"We work a lot about her getting connected with her power source and her center, following her own knowing."

Respondents' accounts of power were more concrete and specific when they discussed the ways that they, as therapists, acceded power. Such strategies involved offering respect, unconditional approval, acceptance, and personal confidences. In these accounts, therapy was figured as a closed system, a zero-sum game, as the phrase "equalizing client-therapist power differentials" implies. If the therapist relinquishes (some of) her stock of power, then the client's stock increases. There is a paradox in this model, of course: When one party gives over power to another, parity can only be achieved at one level. At a meta-level, the giver remains in control of the situation.

As therapists, respondents' feminist commitment to helping women was expressed within the private space of the therapy relationship. In that setting, helping women feel efficacious is perhaps the best that can be done. But our respondents were well aware that promoting feelings of empowerment is not the same as rectifying social injustice. Once the topic of conversation shifted away from feminist therapy to the feminist movement, many respondents spoke eloquently about injustice, domination, and oppression, noting that power and privilege were not fairly distributed in the world outside of therapy, even in such intimate social systems as relationships and marriages. But even though some respondents were angry that the feminist movement had (in their view) turned a blind eye to the ways that class, education, and other material resources were implicated in power, they did not bring this same critique to bear on feminist therapy. The line they drew between "political" work and "clinical" work was thick and

clear. Working for social change was seen as an important task but one unrelated to the work of therapy. To quote one respondent, "...when I think about quitting therapy, I think I would do social change stuff."

5. Secret identities: Feminism by another name

In the 1990s, feminists have been called political extremists, "man-haters," whiners, lesbians, femi-nazis, bluestockings, and enemies of the family. The media has captured the term feminist and imposed on it negative meanings unrecognizable to most feminists. (As one respondent said, "If I met someone who was labeled capital-F feminist, it would give me pause...as to what that person was about.") This put our respondents in a discursive predicament. Feminism was an important part of their identity and their personal histories. Many worked in feminist-inspired agencies; some had thirty-year records of feminist activism. Yet all but one expressed reluctance to use the label feminist in the present cultural climate. Some told us that the label pegged them as "man-haters" and "ball-busters." Most did not call themselves as feminists in public communications (such as business cards and advertisements); some also avoided the term in conversations with clients. Some invented alternate names for feminist therapy:

"I would probably refer to it as 'woman's therapy,' since feminist therapy is.... It's a turn off to [men], so I have a tendency to not use that word."

Thus the feminism of our day, a movement that began with Betty Friedan's discovery of the "Problem That Has No Name" (1963), now is at risk of becoming the "Movement That has No Name."

Feminist critics of psychotherapy have continually assailed conventional therapists for not owning up to their values. Writers on

feminist therapy have always claimed this as a cornerstone of feminist therapy; feminist therapists would "come clean" about their values at the onset of therapy, thus assuring clients' right to informed choice about their therapist (e.g., Hare-Mustin, Marecek, Liss-Levenson, & Kaplan, 1979; Laidlaw & Malmo, 1990). But in the anti-feminist climate of the 1990s, the practice has reversed and feminists deliberately conceal their values. Some respondents justified this practice on blatantly pragmatic grounds: If they reveal their feminism, they will lose business. Others justified soft-pedaling their feminism by re-interpreting their clients' antipathy toward feminism, viewing it as, for example, an unconscious "survival strategy," a matter of "false consciousness" or "being in denial." We find such justificatory practices troubling. They run the risk of patronizing women and disrespecting their ability to think for themselves.

Practices of concealment may appear to solve an individual therapist's worries about her image. But concealment undermines feminism as a whole. If moderate and "reasonable" feminists go underground, then the media image of feminists as extremists will become a self-fulfilling prophecy. Abandoning the term feminist seems tantamount to surrendering to mass culture without resistance.

Conclusions

We sought to examine at close hand how a small set of thoughtful and committed practitioners have brought feminism to their work. As a group, our respondents were more educated than therapists in general. We deliberately oversampled those with Ph.D.'s and MD's; about 25% of those who identified themselves as feminist therapists in our screening interviews held those degrees, compared to 50% of the sample.

Moreover, we excluded practitioners with bachelors degrees or less, and those with training only in dance therapy, art therapy, or drug and alcohol counseling; such individuals accounted for 10% of feminist therapists in the screening interview.) Nearly all of the respondents lived in or near Madison, Wisconsin, a progressive, politically liberal community. Madison is also home of a major university, well-known for its mental health training programs and its Women's Studies program. Thus we cannot draw conclusions about what feminist therapists in general think or how they practice therapy.

We entered this study with a vision of feminist therapy as a social practice that joined together feminism, with its commitment to social and political change, and psychotherapy, with its commitment to personal change. Our interviews suggested a different vision. Respondents spoke from within psychotherapy culture, grafting serviceable elements of feminism onto its practices, language, and assumptions. Their approach to therapy privileged private meanings, feelings, and ideas. The subject of their therapy was the modern, individualized self; the goal, personal fulfillment and self-discovery. The feminist ideology that our respondents brought to their work took its shape from within this framework. Its core constructs, womanly ways of being, are located "within" the individual self. Its focus of concern is mental life, not political change. It is a feminism that works within existing systems of power operating in society and does not challenge them.

We were surprised by our respondents' immersion in and allegiance to psychotherapy culture. We had expected feminist therapists to be somewhat conversant with developments in academic

Women's Studies and feminist psychology. Instead our respondents drew their knowledge from other therapists and workshops and institutes conducted exclusively by and for therapists. As Laura Brown (1994) has pointed out, feminist therapy has for the most part developed outside the academy, and this separation has had benefits as well as losses. Among the benefits she notes are freedom to experiment and willingness to take risks. But a negative consequence is intellectual isolation. Our respondents, for example, seemed unaware of critical debates regarding the theories that are the foundation of their practice. Moreover, contemporary feminist writings broach issues that we believe are important in therapy -- cultural diversity, racism and white privilege, men and masculinity, child sexual abuse and false memory. It is for feminist scholars in the academy to confront the question of why their writings do not reach or perhaps appeal to therapists.

An eminent psychologist once observed that psychology follows culture, but at a respectable distance. The feminist therapists we interviewed too have "followed culture," shifting to accommodate the shifting politics of the cultural mainstream. Therapists, if they are to succeed, must enter the assumptive world their clients inhabit. But, to do their best work, we think that feminist therapists should enter those worlds as nomadic subjects. To borrow Rosi Braidotti's (1994) persuasive arguments, the multiple positionings of a nomadic subject can produce reflexivity and critical consciousness. These qualities can help therapists resist the gentle slide into the prevailing hegemony.

Footnote

1. The Stone Center publicizes its work primarily through institutes, conferences, lectures, and audiotapes; most of the respondents had learned about Stone Center ideas through oral rather than written means.

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